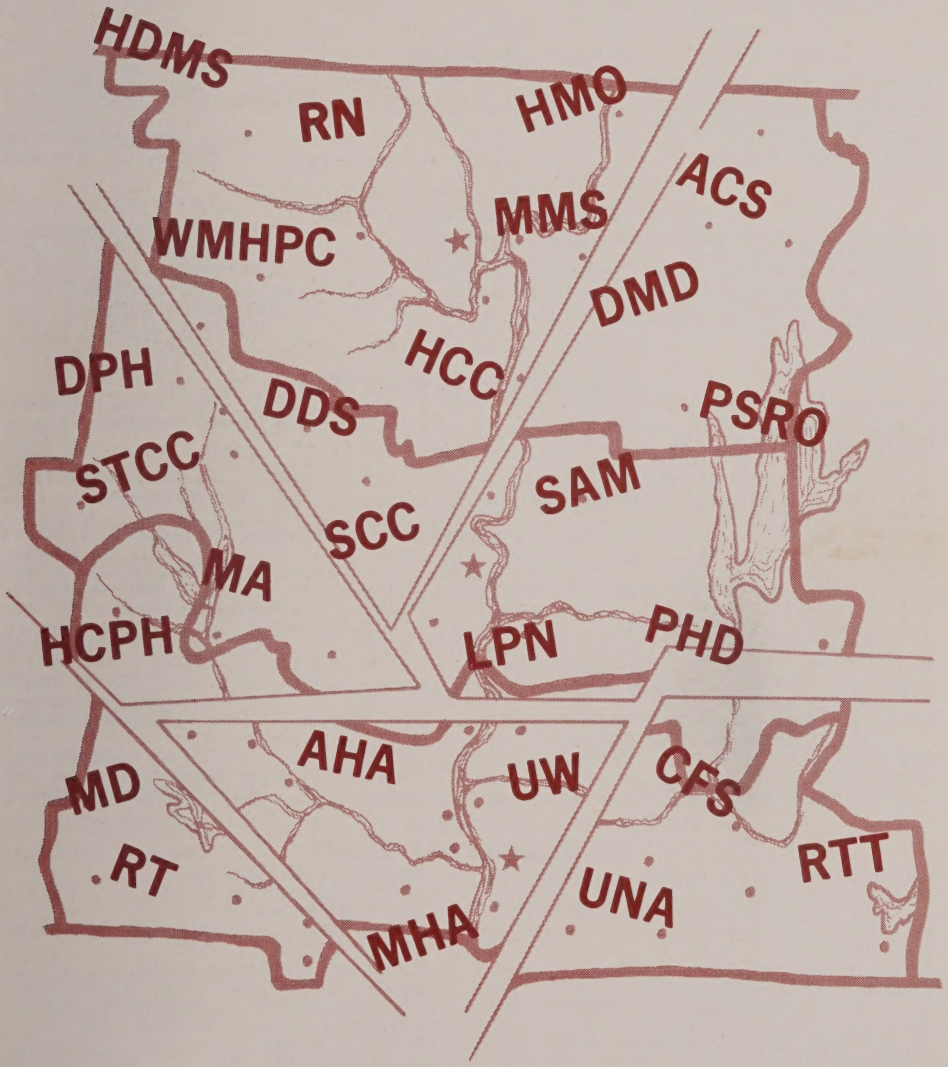
The Hampden Hippocrat

JANUARY
1974



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THE HAMPDEN HIPPOCRAT

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VOL. XXX, NO. 1 JANUARY 1974

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The official bulletin for The Hampden District of The Massachusetts Medical Society. Founded in 1942 by Edward P. Bagg, Jr., M.D. and William A. R. Chapin, M.D.

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NEXT MEETING

of the

HAMPDEN DISTRICT MEDICAL SOCIETY

Tuesday, February 5, 1974

Business Meeting at 6:00 P.M.

Social Hour at 7:00 P.M.

***Dinner — 7:30 P.M. — Courtesy of HDMS**

The Opera House, Yankee Pedlar, Holyoke
Exit 16 off of Rte. 91. Holyoke and South Hadley

Speaker — Richard E. Palmer, M.D., Secretary
Board of Trustees, American Medical Association

YOUR PRESENCE IS URGENTLY REQUESTED

Walton E. Stevens, M.D., Secretary, HDMS

***If you must cancel your dinner reservation, please call the office before noon on Feb. 5, 1974.**

Synopsis:

RICHARD E. PALMER, M.D.
Secretary-Treasurer, AMA Board of Trustees

Richard E. Palmer, M.D., a pathologist from Alexandria, Virginia, won his second three-year term on the AMA Board of Trustees in June, 1973. He has been secretary-treasurer since June, 1972. Before his election to the Board he served on the AMA Committee on Health Care of the Poor, Committee on Government Medical Services and Council on Medical Services.

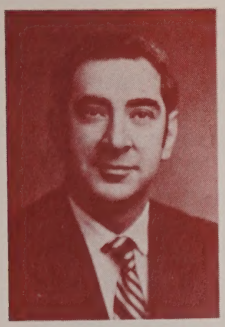
Dr. Palmer earned his A.B. and M.D. degrees at George Washington University in Washington, D.C. Since 1963, Dr. Palmer has been Associate Clinical Professor at the university's school of medicine.

In February, 1973, Dr. Palmer was installed as president-elect of the 2,500-member International Academy of Pathology. He previously served the organization as a member of its executive council and was vice-president in 1972.

He is a diplomat of the American Board of Pathology and in 1967 began a six-year term as Trustee.

Dr. Palmer is chairman of the Board of Commissioners of the Joint Commission on Accreditation of Hospitals. He has served as a commissioner representing the AMA since 1966 and was chairman of the JCAH standards committee from 1967 to 1971.

He is a member of the College of American Pathologists, American Association of Blood Banks, American Society of Nuclear Medicine and the Subcommittee on Pathology Manpower Needs of the National Research Council.



Your President's Page

The Battered Child Needs a Breath of Life

The abuse of children or child battering may be described as the infliction of bodily trauma upon a child so as to wilfully and knowingly cause injury and even death. The intentional neglect and abuse of children may range from deprivation of food, clothing, shelter and parental love to direct physical maltreatment, which, not infrequently, requires hospitalization and potential demise of the infant.

When one studies the demography of child abuse throughout the centuries, one observes the extreme; the practice of infanticide, an act committed by almost every "civilized" nation since recorded time. King Nimrod of Babylon, upon being informed by his astrologer that a baby would be born in Mesopatamia who would declare war upon the king, slew every first born in his kingdom. The calculations from historians estimate over 70,000! The New Testament begins with "the slaughter of the innocents" from which Jesus was saved. The classical philosophers as Seneca, Plato and Aristotle advocated and maintained that killing defective children was a judicious custom.

The advent of urbanization, technological and industrial revolution, heralded a new phenomenon—that of *child abuse*. Kempe and Helfer in their book, "The Battered Child," cite the profound inhumanity occasioned by the factory system: children from 5 years of age and upward worked with irons riveted around their ankles to keep them from running away. They were beaten, starved and in many other ways maltreated. Many succumbed to occupational diseases and some even committed suicide, few survived for any length of time. Child abuse is one of the major social illnesses of the industrial age. Dr. Vincent J. Fontana, Director of Pediatrics at St. Vincent's Hospital in New York, addressing the AMA Convention in 1973, estimated a minimum of 1.5 million cases of child abuse and neglect in 1973. He further added that some 300,000 children will be permanently injured both physically and emotionally in 1973. A more sobering and grave data reveals that some 50,000 children will face death, attributed to maltreatment, this year alone! These statistics strongly suggest that child battering is probably the most common cause of death in children today, outnumbering those caused by infectious diseases, automobile accidents and leukemia.

According to Dr. Helfer, three integral components underlie the cause of child abuse: (1) the potential for abuse; (2) the very special kind of child and (3) a crisis or series of crises. Parents who abuse their children invariably have come from emotionally deprived homes where they themselves experienced disastrous rearing experiences when they were small. In a substantial number of cases there is marital discord between parents. The second component is the child himself, who may be the one extra child the family can ill afford. He may be hyperactive, continuously crying and demanding and well have been born with congenital defects. There are many families hovering on the brink of economic deprivation, peaked emotional stresses and the last newborn may be the last straw which triggers off the crisis for physical abuse.

(cont.)

An interview with Mr. Glendon M. Geikie, newly appointed supervisor of the Division of Family and Children Services, in Springfield, reveals that there is a steep rise of child abuse in our own city. To obtain some statistical data of the Hampden and Hampshire districts. I spoke at length with Mr. George M. Reichert, District Executive of the Children's Protective Services. This is one of eleven regional offices in the Commonwealth, privately endowed and in part supported by the United Way. He offered me the following statistical data of the number of reported child abuse cases: in 1970, 1200; 1971, 1400; 1972, 1558 and he estimates upward of 1800 in 1973. The physician, social worker, child psychologist and the law enforcement officer is cognizant of the magnitude of child abuse. Is the public and our state and federal legislatures aware of the seriousness of this pitiable and pathetic problem? It is frightening to note that since the inception of a central registry in New York, since 1966, the rate of abused children reported has increased 549 per cent!

There has been some reluctance in the past of the professionals and hospitals in the reporting of such cases to the local Child Protective Services and to the Division of Family and Children Services of the Department of Public Welfare. This reluctance in part is from concern that if such a report is filed, the professional or the private citizen or the institution may be open to liability, if it should turn out, for example, that the charges of child abuse cannot be sustained.

The 1964 Legislative Provisions of the Commonwealth of Massachusetts, Chapter 119, Sections 39A; 39B and 39C, authorizes the reporting of child abuse. According to legal authorities, any person or institution participating in good faith in the making of a child abuse report is granted express statutory immunity from any liability whether it is civil or criminal that otherwise might have been incurred or imposed as the result of making of such a report.

It is not enough that we as physicians and social workers and child psychologists and hospital administrators report each and every case of suspected child abuse. We need much more than this. We need the input of every concerned citizen and dedicated state and federal legislators to understand the magnitude of child abuse and demand a priority to eliminate this plague and social disgrace. The professionals have estimated that five hundred million dollars a year would stem and rectify the horror of child abuse. How do we equate the 25 billion dollars spent in the past decade for space exploration with an annual death rate of 50,000 children a year from malnourishment, maltreatment and physical abuse! Their parents are mentally ill, approximately two thirds of the families are socially and economically deprived and all desparately needing professional help, while some require financial stability to rehabilitate themselves. I stand aghast at man's accomplishments: the discovery of fire, the wheel, the building of pyramids, compositions in art and music, ships to cross the oceans, tele-communications and advances in medicine and yet, I feel pathetic. If man does not have the sensitivity to reach out and nurture, the yet unbudding flowers of his race, I seriously ponder the meaning of civilization, man's merits and purpose of his living.

S. A. Zacarian, M. D.

* * *

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EDITORIAL . . .

Getting It All Together — Another Year, Another Chance

The New Year has provided the theme for this month's *Hampden Hippocrat;* a new chance to get it all together. The real and imagined forces dividing our attempts to provide better health care for the citizen-patients of our district medical society need to be identified, evaluated and then subjected to the composite mind of all concerned with health care. Agencies and organizations exist which offer only partial solutions to the total problem of health care and its delivery. Unless a coordinated attempt is made by organized medicine—*to get it all together*—it will find itself as one of a fragmented segment pushed into place by others with very different interests and opinions of medicine's i.e. the physician's place in the total health care delivery system. The acronyms scattered over the cover represent some of the personnel and agencies involved in the delivery system.

Some of these providers and agencies were asked to contribute an article about themselves and their services. The response was not 100%, the style varies with the author and not all articles submitted have been published. Our dental colleagues and their substantial contributions will be presented in a later issue.

(cont.)

Courtesy Medical Society Magazine Group

Divisions of Our Local Health Care System:

Identification of the divisions within our system of health care may assist in determining the forces in action, their interrelationship and offer clues as to how they can be gotten together. There are at least nine in number and the reader may wish to add a few of his own. The forces from within the divisions generate energy which contributes to the momentum of the system. A breakdown or slowdown of any single or combination of the divisions will result in a failure of the system to deliver the necessary care. The physician is unique in that he can appreciate the roll of each division and can contribute to its efficient thrust; he need not be in control. In fact, in some divisions he is poorly prepared to manage and his advice alone is sufficient. The following divisions are broadly sketched and abbreviated in content.

1. *Personnel*—all medical, dental and paramedical individuals with their respective bodies of organization and self-representation;
2. *Hospices*—(by definition extension) all those institutions providing incare services i.e. away from home services for patients;
3. *Agencies*—the social, voluntary, religious, welfare and inhome organizations which provide assistance for patients within their homes, or non-hospice organizations or provide transportation;
4. *Public Health*—the city, state and federal groups responsible for maintaining the common weal;
5. *WMHPC*—an arm of the state's licensing prerogative and data gathering organization and a surveyor of some of the community's health needs;
6. *Third Party Payors*—to provide the insurance principle to equate costs;
7. *Licensing and Regulation*—from those departments, in all three levels of government, charged with the application of the law to the health field;
8. *Training Schools*—those licensed facilities wherein instruction is provided to individuals entering the delivery system;
9. *Continuing Medical Education*—the responsibility of each professional group in Personnel.

Brief Editorial Thoughts of Some of the Problems of the Divisions:

The following brief paragraphs are meant to be used as "openers," to provide the reader with starting points for his own thinking and hopefully feedback to the *Hippocrat*. The data gathered and collated by the WMHPC has revealed the excesses and deficiencies in personnel and hospices but has not been widely distributed to the leaders of the various professions and trades envolved in the system; thereby allowing these individuals to better provide their speciality's services. Although the HDMS has been asked to provide input through committee action, more cooperation is necessary. Even though the physician is a provider and is limited in numbers by law to a minority, his contributions should be more widely sought. This should be through the HDMS's appointees and not a random physician selection by the WMHPC. Similar concern should be extended to the other health professionals.

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Human nature changes slowly and hospital loyalties remain strong. It is self evident that each of the area's hospitals can not be all things to all men. The needs of the community for acute beds, for nursing home facilities and other in-care services have been detailed by the WMHPC. It behooves the Boards of Trustees and their administrations to divide the workload and patient burden according to ability and resources within their institutions. Duplication of efforts is wasteful in money and manpower. At least a détente for 1974 would be a major step forward, especially before it is legislated.

Review of the articles submitted by the various agencies established to provide outpatient, inhome or transportation services to patients of the district revealed a multitude of services and much overlap and a lack of coordination of efforts. This division of the health care system is the weakest and needs the concerted help of the HDMS to assist in balancing the numerous forces therein. A worthy project for a special presidential committee.

Public Health in Springfield is well managed by Dr. John C. Ayres, but the other cities and towns in the district lack a Commissioner of Public Health. Could a viral hepatitis epidemic be discovered, contained and controlled in Holyoke? Can the HDMS through its Public Health Committee help in the coordination of municipal public health programs and disaster plans?

At the district level, there is little to be done about third party payors. Herein organized medicine's voice is best heard at the Massachusetts Medical Society level. The Foundation may enter into dialogue with the payors but this is not HDMS business. A need exists for catastrophic insurance but again the MMS should be the spokesman for the physician. The HDMS should have an ad hoc committee which would keep abreast of the national legislation dealing with National Health Insurance programs under study in the Congress. Even though the AMA and MMS are doing such, the local problems of our district should be anticipated so that we can act and not react.

Problems arising from new legislation and regulations are best relegated to our parent organization the Massachusetts Medical Society. Our legislative councilor can apprise the district of any necessary action. However, we physicians must be willing to write the letters or visit our legislators to indicate our support or lack thereof for pending measures. Local dialogue with the welfare offices is also a must; pressure for prompt payment for services rendered must be maintained.

There is an adequate number of training schools for the preparation of paramedical personnel. Liasons being established by area hospitals with regional medical schools are excellent introductions for bringing young future physicians into our district. Some are bound to find us and the area satisfactory for their practices. There is no feedback as to availability of jobs nor no central agency to assist in job finding either for physicians or for paramedical personnel.

(cont.)

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The need for continuing medical education is self-evident. Within our district are major hospitals which underwrite excellent lectures and training programs, attendence is often limited to immediate hospital staff because of scheduling and poor publicity. A policy of printing hospital educational programs was not too successful. An external coordinating force seems best and the Springfield Academy of Medicine could well act as that force. Formal lectures required by the JCHA for each hospital could well be combined so that each speaker is assured of a large attentive audience for general subjects and when feasible the meetings could be divided into major specialities lectures with several speakers, on the same night in different auditoria. The Academy could keep an accounting for P.G. credits.

Concluding Thoughts and Remarks:

The physician remains the *keystone* of the arch in today's health care and delivery system. The increasing complexity of modern medicine, the ability to prolong life with disease not eradicated, the geometric doubling of health care knowledge and data precludes that any new breed of physician (and us oldies as well) can successfully balance and buttress all facets and divisions of patient care. He can provide and must provide the stabilizing force to the arch as its keystone. Through manipulation of the proper channels and divisions, he can provide total satisfactory care for all his patients. The experience of the business world introduced by hospital administration, the WMHPC and the third party payors will be able to stabilize and control expenses to the patient. PSRO will provide the fulcrum to balance necessary expense against unnecessary costs. A restructured third party payor must provide the funds necessary to underwrite the tremendous expenses often concomitant with and generated by the health care system's ability to repair and prolong life.

The physician, who realizes the limits of his training and knowledge, can assure proper incare service for his patients by cooperating with the peer review committee of his hospitals and by requesting associate staff privileges in several of the area hospitals which have undertaken programs of specialization in limited fields of health care. It should be obvious that no physician can master all divisions within the evolving health care system but his local district society can and should.

The year of 1974 *could* see the Hampden District Medical Society regain its rightful position of leadership by providing the coordinating force *to get it all together* and unite the nine divisions of our local health care system.

A healthy and happy New Year from your Editor.

W. E. Stevens, M.D.

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Child and Family Service

Child and Family Service of Springfield, Inc., located at 367 Pine Street, is entirely devoted to the human relations field. Founded in 1870, for over a century it has served the people of Hampden County in a variety of ways.

The core service of the agency is counseling in all its facets: *Marital Counseling* is designed to help people face the many pressures and problems in their life together. *Parent-Child Counseling* gives professional help to parents in their job of bringing up children, and to children in their job of growing up in their parents' homes. *Financial Counseling* is available for people who have trouble managing income to cover needs. With this service, we have a limited amount of money for financial assistance to give if the situation calls for this. *Family Counseling* calls for discussion with the whole family and the problems they are having living together. Workers skilled in family treatment help them to express how they feel and take a look at how they act toward each other. *Group Counseling* consists of people working out their problems in groups of 8 to 12 people for regular meetings. These groups may consist of young people, parents, married couples, or single parents. *Personal Counseling* is available for people whose problems seem hard to solve alone. *Family Life Education* is available to groups who are interested in trying to anticipate problems and hopefully eliminate them before they become full blown.

Branching out from our counseling service is our *Homemaker Service.* This service is available when a wife is ill and the children or others in the family need a warm, capable person to take over the homemaker tasks until she is well. We also have a homemaker service for older persons to help them maintain themselves in their own homes as long as is feasible. This often delays or eliminates the need for institutionalization, which is costly in both human and financial terms.

The agency is available to unmarried parents—to help the single pregnant woman with planning for her baby and with her feelings about the pregnancy. Involved, too, whenever possible is the father of the child to help him with his feelings and to try to involve him in the planning for his child.

We have a *Foster Home Program* where the foster parents give loving care to these babies until some permanent plan is made for them; either they are released for adoption, or the mother decides to have the child live with her.

This agency is also available for consultation with other agencies in the community when we have a mutual client or when we have knowledge of new ways of working with people in trouble. Also, we are quick to call on other agencies who have more expertise than we on certain problems arising among our clients.

Child and Family Service also serves as a field placement experience for students from area colleges and schools of social work. Here the student, under close supervision, works directly with clients. We are happy to perform this service as the students bring new enthusiasm and a fresh approach to social work. We feel the time spent in their instruction is an investment in the future for all of us.

(cont.)

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Any person coming to Child and Family Service can be assured of being graciously received, of being seen with a minimum of delay, and of being counseled by trained, professional social workers, most of whom have Master's degrees. We do like to set up appointments for interviews, but do have a walk-in service where a person can be seen on an emergency basis.

We are open from 9 to 5 Monday through Friday and in addition we are open two evenings a week, Monday and Thursday until 8:30.

It is our wish to be able to reach out and alleviate some of the needless suffering of people with problems who feel they have no place to turn. We cover all segments of the community, the rich, the poor, and the middle-income—and we do not discriminate on the basis of race or creed.

We are available to all.

Edwin A. Abusamra
Child & Family Services
Springfield, Mass.

"We must all hang together, else we shall all hang seperately."

July 3, 1776

Benjamin Franklin to John Hancock, upon signing the Declaration of Independence

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The Hampden College of Pharmacy

The Hampden College of Pharmacy was founded in 1927 as a tutoring school under the name of Western Massachusetts School of Pharmacy. The school was founded here in Western Massachusetts because the nearest Colleges of Pharmacy were situated in Boston, Massachusetts, Providence, Rhode Island, and New Haven, Connecticut. This school began with one student and one teacher in January 1927 at 67 Cabot Street, Holyoke, Massachusetts, in the rear of the Gagne Pharmacy, as a tutoring school. The School grew, so that, in 1934 we moved to 71 Cabot Street to a five-room apartment; and in 1938 we moved to 694 Chicopee Street, Chicopee, Massachusetts—our present location.

The curriculum was three days a week for three years, and shortly after a program of five days a week for five years was initiated on an academic basis from September through May. At the same time the tutoring classes were still held in the evening. The School was incorporated in 1944 under the General Laws of Massachusetts under Chapter 180 as a non-profit sharing organization. We were approved by the Board of Registration in Pharmacy and the Board of Education in 1946. We were also granted the power to grant a Bachelor of Science Degree in Pharmacy in 1950, and we were to change the name to Hampden College of Pharmacy in 1954.

The curriculum at present is a five-year program, with a one year Pre-Pharmacy and four Professional years in Pharmacy, Chemistry, Materia Medica and Allied Sciences. Upon graduation and receipt of the Degree, the graduates must then appear for examination by the Board of Pharmacy for registration, thus giving them the right to practice Pharmacy in the Commonwealth of Massachusetts.

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HOSPITAL PHARMACY (or CLINICAL PHARMACY)—this is complete training in the clinical program course, admission to hospitals, different phases of treatment for each individual patient until the patient is discharged. All classifications of medication and proper dosage for each patient dispensed according to hospital requirements.

DETAIL MEN—these men are trained by the respective manufacturer of medications for companies such as, Lilly, Parke-Davis, Abbott, Upjohn, Merck, Squibb, Ciba, Smith Klein and French, etc. They must know product information of the company's manufactured items and transfer this information to the Physicians who prescribe them.

DRUG SALESMAN—is a person, who, for the most part, introduces the products to the different Pharmacy retail stores. In this way, the wholesalers will have the items in stock—ship to retailer—when it is necessary to fill a prescription.

RESEARCH—is comprised of a team in the large manufacturing houses of six or seven men (women) having advanced degrees: i.e. PhD., M.D. or a combination of both, an M.S. or B.S., a Veterinarian, a Pharmacist. This team will work on a new product development, or improving on products already being manufacfactured. This work continues until the item is perfected or discarded such as: pills, tablets, suspensions, elixirs, syrups—and this is usually decided on by the pharmacists. The research department will have 450 to 500 employees.

MANUFACTURING—the products obtained must be manufactured in large quantities including manufacture, bottling, labeling, etc. They will have glass lined tanks for the manufacture of penicillin, and require 10,000-30,000 gallon tanks for syrups, elixirs, and tinctures, etc. These preparations all come under the department of technical control at each step to insure purity and quality control.

ARMED FORCES—All branches of the Armed Services have Pharmacists in Veterans Hospitals, Camps and air bases have Pharmacy Departments to dispense prescriptions and medications.

GOVERNMENT AGENCIES—Bureau of Narcotics and Dangerous Drugs, the Food and Drug Administration, the FBI, and Customs' Officers etc. The pharmacists in this department check pharmacies, hospitals, legal and illegal drug outlets (BNDD, FDA, FBI). Customs check at ports of entry to the United States.

TEACHING—graduate pharmacists teach chemistry and biology in high schools in the area.

The aim of Hampden College of Pharmacy is to educate young men and women in the field of Pharmacy. The greatest advantage of this College is that students can commute, live at home, and work while attending to earn money and gain experience in retail stores in Pharmacy. The largest percent of our student body come from a radius of 60 miles. Sixty percent of the registered pharmacists west of Worcester are graduates of the Hampden College of Pharmacy.

DR. JOSEPH GAGNE—DEAN
Hampden College of Pharmacy

MYLANTA
FRANK BOBBIN

The Hospitals' Outlook and Problems

In attempting to take a look at the future of medical and health care, it appears to be wise to review the atmosphere of where we are now. Interestingly, physicians and hospitals are cast in the same image by the majority of the public: both charge too much and both don't really care about the sick individual. Interestingly also this generalization applies when individuals are talking about *physicians* and *hospitals,* but usually disappears when the individual talks about *his or her own* physician or *his or her own* hospital. Nevertheless, we in the medical and health fields must face facts—the public—educated and uneducated, rich and poor—believes being sick, or even examined, costs far too much.

Now where has that belief led us so far? For better or for worse, it has given us Medicare and Medicaid; it has given us Utilization Review and Professional Standards Review Organizations; it has given us State and Federal Certificate of Need Laws; it has given us new State Department of Public Health Rules and Regulations and some new Joint Commission on Accreditation of Hospitals standards and recommendations; it has given us a Federal Economic Stabilization Program, Phases I, II, III, IV, with a Cost of Living Council as its arm; it has given us a Massachusetts Rate Setting Commission; and it has given us the Occupational Safety and Health Act. Undoubtedly there are many more.

To illustrate the type of conflicts we are all in: The Department of Public Health may write new rules in a variety of areas which will substantially increase costs; yet, no real prior approval of these increased costs can be obtained by the Rate Setting Commission. Superimposed are the Federal rules from the Social Security Administration on Medicare and Phases I through IV. Their interpretation may or may not coincide with anything decided on the State level.

Most of these programs apply specifically to the medical and health fields, with the exceptions of Phases I through IV and the Safety and Health Act. Both, of course, apply to all segments of the public and the economy but interestingly, the Safety and Health Act has increased substantially the costs of running a hospital through compliance with its provisions while at the same time Economic Stabilization has been enforced with vigor on the medical and health fields, often when relaxation or just plain dropping has occurred with other fields and industries. To justify this, we, physicians and hospitals, have been told we are special cases.

In a short span of less than ten years physicians and hospitals have gone from providing care to people in a free enterprise atmosphere to an over-regulated situation compounded by overlaps and contradictions generated in these federal and state programs, laws, rules and regulations. Massive bureaucracies have been set up to make the rules from the legislative intent and many, many people—mainly accountants, consultants, and lawyers have been hired by physicians and hospitals to attempt to comply with and understand the rules and in some instances, to fight or challenge the rules. Thus the costs of government—the regulators—have risen sharply with the intent of "control physician and hospital costs," while the costs of those providers—the regulated—have risen sharply to meet the rules. Who knows which has cost more to date?

As disturbing as these growing bureaucracies are and have been, there are two elements which are more disturbing and they both relate to a non-existent National Health Policy. The first element is an ongoing attempt by the bureaucrats, especially those connected or allied with Phase IV efforts federally, to establish a level of the Gross National Product for health care. These bureaucrates have decided that the current about 8% of the Gross National Product is enough and it should not go higher! I know of no studies which have evaluated how much is enough. Should it be 10% 15% or 7%?

(cont.)

The second element, which ties into the first, is that many federal grant and contract programs, under Health, Education and Welfare, National Cancer Institute, National Institute of Health and others are geared to spending more money to improve the quality and quantity of medical and health care—not only to those who may not now have enough care, but also to the vast majority who have a good or excellent level of care. This segment of government espouses an obvious recognition of a rapidly changing technology, the benefits of which should be transferred to the patients. But it costs money and it might increase the share of dollars spent for health or the Gross National Product!

What does this all add up to? It adds up to me that we, as a country, are rapidly moving toward state or socialized medicine—*but by the back door.* The bureaucrats in writing the rules after Congress or the Legislature acts—are reflecting their own philosophies and are developing a national health policy—one which has an economic lid on it. Such a move can only be detrimental to patients and the public in the short and long haul. It is obvious to me we need a well-enunciated National Health Policy, the implementation of which could and should be staged in order for us to be able to afford it. The implementation should also eliminate the existing over-regulation, overlaps and conflicts. It should also permit as much free enterprise in it as possible.

The trends of the last decade will continue—more and more medicine will be practiced in and around the hospital—more and more hospitals will work together cooperatively and on a regional-type basis—more and more medicine will be organized along the lines of health maintenance organizations. All of these will continue at the present pace. All of these could accelerate depending on a National Health Policy and Program. There is no question we will have a National Health Program within five years.

The real questions are: Will we have a Policy which reflects what the public wants, not back-door socialized medicine? Will that law enacted by Congress be detailed enough at the policy level to prevent vicarious bureaucratic interpretation?

I firmly believe health providers, physicians and hospitals mainly, must now work together to achieve a good and workable National Health Policy and help to guide the country into a policy and program which is workable, feasible, and sensible—and not overburdened with federal and state bureaucratic rule making.

Robert F. Tuveson
President, Wesson Memorial Hospital

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Through the United Way of Pioneer Valley people are helped in many ways . . . a lonely citizen is provided with a hot meal . . . a visiting nurse provides medical care to the homebound or instruction to a pregnant adolescent . . . an emotionally disturbed parent receives psychiatric treatment.

It's an expensive task—paying for food, equipment, facilities and professional services—the cost cannot be paid for by a few. This year the United Way will spend $1,750,000 to keep people helping people. This money will not foot all the bills, only the difference between what participating agencies glean from fees and what it actually costs to open their doors.

United Way agencies cannot earn enough from their fees to stay in operation because of one fact; no one can be refused service. But neither are these services a "free handout." Fees are charged based on a sliding scale system. Anyone who cannot afford the full cost is asked to give what he or she can afford. United Way funds make up the difference.

Of the 55 United Way services, those providing medical services include the Visiting Nurse Association, the Hampden District Mental Health Clinic and the American Red Cross.

Agencies involved in rehabilitation include United Cerebral Palsy of Western Mass., the local chapter of the National Cystic Fibrosis Foundation, Drug Abuse Foundation of Pioneer Valley, Goodwill Industries, Salvation Army and the Mass. Correctional Association.

The United Way of Pioneer Valley serves the communities of Agawam, East Longmeadow, Hampden, Longmeadow, Springfield, Westfield, West Springfield and Wilbraham.

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People were worried about the future way back in the 1940's . . . about the way Americans lived their lives, without regard for their health. A group of these concerned individuals became so motivated by the crisis confronting Americans that they formed the American Heart Association—twenty-three years ago, on June 5, 1950, the Western Chapter, Massachusetts Heart Association, came into existence with Dr. James Naurison serving as its first president.

Dr. Naurison piloted a small corps of dedicated people into a three-pronged attack on heart disease, through professional education and research.

The need for volunteer support was evident to these first members of the Heart Association, for only through the support of a concerned group of volunteers could the Heart Association further its efforts. The task seemed insurmountable in "the good ole days," but the volunteers were found, and funds began trickling in.

The firm stand taken by the charter members of the Heart Association caught hold and is still present. The Heart Association is built upon the shoulders of volunteers. The unselfish attitudes and dedication of these people induced more people to actively join the fight against heart and circulatory diseases in Western Massachusetts.

If volunteers were the backbone of the Heart Association in those early days, then funds must be considered the blood of the organization. The same as it is today.

Through the support of a generous public, the Chapter no longer needs to fight for recognition and survival, but rather can put all its effort into fighting the diseases which are responsible for over 54 percent of all of the deaths in Hampden, Hampshire and Franklin Counties.

In the fast-moving Fifties, the Western Chapter joined the "Jet Age," and created a solid foundation from which to grow. The first ten years of the Chapter's existence were highlighted by many advances in the reduction of death and disability from diseases of the heart and blood vessels.

In the President's report of 1960, Dr. Jacob Weisman said: "Anticoagulants have reduced the morbidity and fatal outcome of coronary thrombosis; the prophylactic use of penicillin has decreased the recurrence of rheumatic fever and thereby, the damage to the heart valves; phenomenal advances in cardiac surgery, aided by the development of new pumps and oxygenators have restored thousands of cardiac cripples to a useful and more tolerable existence; the riddle of arterial narrowing and obstruction is slowly but surely being unraveled by extensive investigation and basic research; the causation and control of high blood pressure and its consequent damage is almost conquered."

(cont.)

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Education played an important role in the Fifties, because these discoveries which seem elementary today, had to be brought to the physicians and the public alike, Community Service programs came into being.

"Ten exciting years! And a future filled with adventure and a challenge to which we gladly dedicate ourselves," were the words of Dr. David Weinland, Chairman of the Board in 1960.

And so the Fifties made way for the Sixties, and the beginning of the Western Chapter's second decade. Skirts reached new heights, and so did the activities of the Heart Association.

Funds continued to be a main emphasis of the Western Chapter, and with each new increase in income, the dividends to the public increased two-fold. Programming was expanded and new peaks were reached.

The year 1961-62 saw the establishment of the Cardiac Evaluation Unit. Membership rose to 116 physicians, and 90 lay people. The third Seminar for Nurses was held, and the 7th annual Symposium took place.

Heart Information Services became a reality in 1963, and residents of the tri-county area could call the Heart Association to dispel any misconceptions which they had concerning heart and circulatory diseases.

The 1963-64 fiscal year saw another increase in Heart Fund dollars. A total of $142,526 was raised by Heart Fund volunteers in Hampden, Hampshire and Franklin Counties.

1965-66 was a year of tremendous growth in the Chapter's public and professional education. The Grand Rounds program was initiated at area hospitals, the third Nurses' Education Conference was held, and the 8th George L. Steele Memorial Lecture was given.

In the realm of public education, over 98,000 pieces of literature were sent to people in the three counties, a Speaker's Bureau was established to provide speakers for groups and organizations.

The "strep kit" program began, offering area physicians a speedy method for detecting streptococcus infections.

The Heart Fund held its first kick-off dinner.

1969-70 saw the continuation of cardiopulmonary programs. Nursing education programs, the Grand Rounds, and the George L. Steele Memorial Lecture, all received with great enthusiasm by the professional community.

The Nursing Education Committee formed a sub-committee to deal with the early recognition of congenital heart defects. Speakers from the Heart Association travelled to all corners of the tri-county area to spread the heart message to clubs, civic organizations and schools.

As the Sixties came to a close, the Western Chapter had a change in faces, ready for the challenge of the 70's.

Mrs. Lillian Bates was appointed Chapter Executive, co-ordinating the activities of the Chapter's volunteers

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with the plans of an invigorated Board of Directors, under the chairmanship of Edwin Gardner and the Chapter's 11th president, Dr. Henry Polchlopek.

1970-71 was the year three firsts were initiated: Literature was distributed to the Spanish speaking population, a Nutrition Education Committee was formed and the first Heart-Golf Day raised $2,000.000.

In the last days of June the Association moved its headquarters to 85 Oakland Street near the "X" in Springfield.

1971-72 saw the untimely early retirement of Mrs. Bates as Chapter Executive. John Eldridge was hired as the new Executive Director in March.

In the annual report of Paul T. Moore, M.D., Chairman of the Board, he said in part, "All in all, the Chapter grows in stature and worth to the counties we serve."

1972-1973 through the regional medical program the Chapter conducted four courses for nurses on coronary care units. The Chapter raised $159,000.00 (not including bequests) and this was the largest amount ever raised.

1973-1974 the Program Council, a newly formed Committee to guide the Chapter in its program activities, sets as priorities: Minority Programming, Rheumatic Fever, Emergency Medical Services, Coronary Care Unit Nurse Training, and Stroke Education.

The success of the past is based upon the dedicated people who were willing to give the extra effort which creates winning teams.

The lesson of history easily exhibits the fact that the Western Chapter Massachusetts Heart Association, has the ingredients to plunge into the future . . . a strong-willed Heart ready to work for the maintenance of healthy hearts of people.

JOHN N. ELDRIDGE—
Executive Director
Massachusetts Heart
Association
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The Hospital Based School of Nursing

This year, 1973, marks the centennial year for nursing education in the United States. The occasion has been celebrated the country over but no where more joyously and proudly than at the Massachusetts General Hospital in Boston; for that diploma school of nursing was one of the three schools to open its doors to students in 1873, and it has carried on the proud tradition of graduating nurses for 100 years.

Growth of diploma schools was rapid and by 1920, there were approximately 1800. However, by the mid 1930's the number had been reduced to nearer 1200 as nursing leaders established educational standards and requested each school to go through a self-evaluation. As a result, many small schools and those with weak programs found they could not keep pace and closed. The result, of course, was a strengthening of the schools that remained with increased enrollment, better screening of applicants, better prepared faculty and a broader curriculum that prepared the nurse for the kind of practice expected of her. Graduates of diploma schools of nursing have been the mainstay and the strength of nursing practice through the years. They have staffed our nursing services, both in hospitals and in the community, served the patients as private duty nurses and assumed the role of hostess, nurse and assistant to the physician in his office.

The years since World War II have seen more schools of nursing offering a basic four year degree program and more recently the development of the two year associate degree program in nursing.

Both have been popular with high school graduates as society emphasized the need for a college degree. Coupled with the trend toward collegiate education, the publication of the Position Paper by the American Nurses' Association re-emphasized the importance of placing all nursing education in institutions of higher learning. The Position Paper sounded the death knell for diploma schools or nursing. The country rocked under its predictions and those who believed there was an important place in nursing for the graduate from a good diploma program rose to do battle.

Eight years later, the clamor has subsided to a degree, but the years have taken their toll. "Facts About Nursing" in the 1970-71 edition showed the number of diploma programs was down to 614, a reduction of 180 programs in six years. Those 614 schools graduated 52% of the professional nurses with a potential of becoming registered nurses. There has been a slow rise in the number of programs offering a baccalaureate degree in nursing and very marked increase in the number of associate degree programs in nursing. Still the majority of nursing graduates are prepared in hospital based schools. A survey of Western Massachusetts brings

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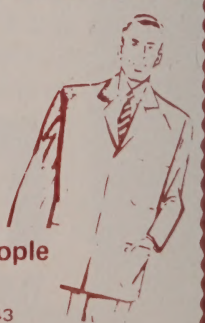

the picture very close to home and repeats on a small scale what is happening everywhere. Two diploma schools, only, remain: the Holyoke Hospital School of Nursing and the School of Nursing of Springfield Hospital Medical Center. Five schools have closed or are in process of closing; i. e. they are admitting no more students. Conversely four community colleges have opened nursing programs. The one basic degree program at the University of Massachusetts has remained essentially the same in number of students.

Programs for nursing education are expensive. The expenses of the University school and the schools in community colleges are paid for with tax money and the public accepts without much question payment of taxes for many types of state programs. The expenses of the hospital based school on the other hand must be borne by the patients who with other segments of the public object to the high costs of medical care. Pressure is on hospitals to reduce expenses. Closure of the diploma school of nursing is one way to do this.

There are many nursing educators, mostly those closely involved with diploma programs who believe the good diploma programs will remain and will continue to be an important source in the supply of graduates for society's nursing needs. While the student of today has much less clinical experience than her counterparts of 20 years ago, the student in the hospital based schools sees and cares for patients early in her first term and spends more time on the nursing unit throughout her three academic years than does the student from either the two year or four year pgoram. The graduate of a diploma program enters practice with more self assurance because she has had the time and the opportunity to be involved with patient care. For those of us who are responsible for planning and implementing the program, we know the nursing curriculum is sound, the graduates do well on State Board Examinations and the graduates make good nurses with the ability to make the sound judgments so necessary in nursing practice and expected of them by the physicians with whom they work.

The problem for the diploma school graduate is the difficulty she faces in obtaining a degree if she decides to go this route. While the science and social science courses taken in a recognized college will give her credits equal to a year of college, no collegiate nursing program is willing to accept for credit nursing courses offered in a hospital based school—so she is faced with taking challenge examinations or repeating all her nursing courses plus taking the necessary liberal arts courses. It could require three more years to obtain a Baccalaureate Degree for a total time expenditure of 6 years.

No paper such as this can be complete without some comments from the employers of practitioners in nursing. Those of us responsible for providing care to the patients are becoming increasingly concerned that the products of all educational programs are, initially, limited in skills and abilities and must have a period of 2 to 4 months in orientation and close supervision before being able to assume the responsibilities expected of them. All things being equal, most nursing service directors believe the diploma graduate will adjust more quickly—especially if she remains in her home hospital and in all probability will assume her place on the nursing team sooner than the graduate of other types of programs.

In spite of the competition with other programs, the hospital based school remains popular with high school students. For one thing, the high school graduate is now wanting a practical education that will offer a vocation. Secondly, they know the program of the diploma school is sound, offers patient involvement to a greater degree than other programs and its graduates are known for quality in care.

There is merit in diploma programs in nursing. It will be a sad day if all such programs are replaced by other types of programs.

Jeanne S. Murphy, R. N.
Assistant Executive Director For Nursing
Springfield Hospital Medical Center

Paramedical Programs at Springfield Technical Community College

As the need for paramedical personnel was felt in the various disciplines of medicine, STCC fulfilled that need and today offers the greatest number of health sciences of any community college in Massachusetts. The aim of the college is to provide properly trained personnel to assist the hospital doctor, or dentist, and other related health service areas in their work so that with the minimum of adjustment these personnel will be able to assume their duties without extensive training by their employer and thus save time and expense. The following programs are presently offered leading to national or state certification with an associate degree where applicable and to a diploma in other cases.

1. Dental Assistant
2. Dental Hygienist
3. Medical Assistant
4. Mental Health Technician
5. Nursing
6. Operating Room Technician
7. Physical Therapy Assistant
8. Respiratory Therapy Technician
9. Medical Laboratory Technician
10. Radiologic Technology
11. Radiation Therapy
12. Nuclear Medicine Technology

In all the above courses practicum and didactics are integrated—sometimes concurrently sometimes consecutively. The practicum is obtained in conjunction with local and sometimes not so local hospitals and dental facilities so that graduating students are familiar with the current state of the art.

I. Dental Assistants

These students are trained to assist the dentist at the chair in the laboratory and in the office. In their training they are required to know of and prepare dental instruments and materials, to be able to take dental x-rays and to run the office thus freeing the dentist for those tasks that require his specialized skills.

This is a one year program the successful completion of which insures the eligibility of the student to take the national certification examination.

II. Dental Hygiene

This two year program leads to an associate degree and eligibility for the national boards examination in dental hygiene together with the state boards. These students acquire the knowledge and skills to perform preventive oral health services including the taking of x-rays. By performing these services for the dentist he is again free to concentrate on those operations that only he is qualified to carry out.

III. Medical Assistants

A one year program is offered in this field but students are encouraged to take the two year program. As the dental assistant is to the dentist so the medical assistant is to the doctor. The medical assistant takes a patient's history and prepares him for the doctor's examination in which she will assist. She is able to sterilize instruments, take blood pressure, set up for examinations and run the office entirely, dealing with insurance forms, typing and record keeping. The medical assistant may be employed by one doctor or by many such as in a clinic and will always be a valuable member of the team.

IV. Mental Health Technician

This two year program for which there is no national certifying body, as yet, culminates in an associate degree. These people will work in the human service field under the supervision of qualified personnel.

(cont.)

V. Nursing

The successful student of this two year program will have an associate degree and will be eligible to take the licensure examination for qualification as a registered nurse. The practicum is devoted entirely to learning experiences and not repetitive tasks from which nothing can be learned.

VI. Operating Room Technician

This is a one year program which takes the student through sterilization procedures together with the knowledge and skills necessary to allow him to assist the surgeon or nurse in the operating room, delivery room or central service department. Skills are developed both in the simulated operating room at the college and at affiliating hospitals.

VII. Physical Therapy Assistant

The successful graduate of this two year program receives an associate degree and is trained to work in the physical therapy department under the direction of a registered physical therapist. Skills obtained in the well equipped department at the college are reinforced with practicum at affiliating hospitals.

VIII. Respiratory Therapy

This is one of our newer programs in the health field and prepares the student to administer treatment and medication by means of the respiratory system. This is a two year course with local hospitals affiliating.

IX. Medical Laboratory Technician

Successful students of this two year program are eligible to take the national certifying examination for medical laboratory technicians. This, together with their associate degree, makes them eminently qualified to perform most of the laboratory work performed in hospitals or clinics under the supervision of the pathologist.

X. Radiologic Technologist

After graduating with an associate degree the student is eligible to sit for the national certifying examination. A half of each day is spent at affiliating hospitals keeping didactics and practicum in juxtaposition. A working x-ray unit at the college is used for x-raying phantoms and for demonstration and verification of x-ray principles. Graduates are able to immediately assume their share of the load on employment because of their familiarity with hospital equipment and procedures.

XI. Radiation Therapy Technologist

A core curriculum is given at the college but lectures and demonstrations in this specialty are given at Wesson Hospital. Practicum is obtained at both Wesson Memorial and Springfield Medical Center Hospitals and after completing the two year course with an associate degree students may sit for the national certifying examination. They treat patients with ionizing radiation under a doctor's supervision.

XII. Nuclear Medicine Technology

In this field students obtain practicum at Wesson Memorial and Springfield Hospital Medical Center while lectures in this specialty are given at Wesson. There is the same core curriculum at the college as in the radiation therapy and the two year course culminates in an associate degree and eligibility for the national boards examination. Nuclear medicine technologists perform diagnostic examinations under the supervision of a doctor who specializes in this field, using radioactive substances and sophisticated equipment.

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The Place of the Licensed Practical Nurse in the Health Care System

Practical Nursing education developed for the most part after World War II in response to a need for bedside or patient care nursing personnel. Legislation was initiated by organized professional nursing which gave the practical nurse legal recognition. This legislation was voluntarily undertaken by professional nurses because they realized that nursing needs could no longer be fulfilled by the nursing profession as then constituted. By promoting the preparation of practical nurses and initiating the legislative acts it gave to registered nurses the responsibility for the work of practical nurses.

Those who have not had an opportunity to observe the licensed practical nurse might have an erroneous image of an untrained, unskilled person of limited ability to perform nursing duties, whereas those of us who are in close association with the licensed practical nurse have an entirely different viewpoint. The functions of the practical nurse are varied and sophisticated, and they may be observed working in coronary care units, intensive care units, general hospitals, chronic disease hospitals, rehabilitation centers, extended care facilities, physicians' offices and nearly any other area involved in service to the preservation of health and welfare.

Very often, at the time of interview a prospective student is asked why she or he has chosen practical nursing as a career. Usually the answer is "to help people" and that caring for the sick is a method by which this goal can be accomplished. In reality, nursing at the practical nurse level offers the best means by which this desire to serve can be fulfilled.

The practical nursing program offers a year of formal education in an approved program of practical nursing, and upon completion the candidate is licensed to practice a type of nursing defined by law. Licensing practical nurses has as its purpose the same objective as licensure of professional nurses: protection of the public. This formal preparation and licensure produces an individual who is a responsible, understanding, and safe practitioner, capable of making certain judgements and helps to bridge the gap in providing optimum nursing care. She or he has the ability to work independently with a minimum amount of supervision in situations not requiring a specialized skill and can be of invaluable assistance to the physician, registered nurse and other members of the health team in more complex nursing situations.

At various times and places, reports have been circulated that practical nurses are not given assignments that fully utilize their abilities, and other times one hears of occasions where the practical nurses have been imposed upon when more is demanded of them by way of performance and responsibility than they are prepared to do. In each situation, an injustice is being exercised: in the former instance, because it has a direct bearing on the efficient utilization and cost of nursing personnel; in the latter, because of a failure to comply or to stay within the scope of educational preparedness of the practitioner the injustice is done to both the nurse and the patient. Either situation could create a morale factor on all staff members because appropriate assignments should be given in compliance with the ability of each individual nurse.

In general, practical nursing has added to and provided the health care system with a group of trained personnel and team members who, under the guidance of other health care deliverers, have the practical expertise to participate in direct patient care as well as the technical skills needed to administer medication and treatment.

(cont.)

In recent years great emphasis has been placed upon continuing education programs, so that the practical nurse can keep up with the fast moving pace of medical science and health care. Indeed in some states legislation has already been passed requiring evidence that the nurse has obtained a certain number of continuing education units (C. E. U.) for continued licensure. These educational units need not be taken necessarily at a college or institution of higher learning but may be obtained through attendance at lectures, seminars, workshops, etc.

Some practical nurses, who are interested in making a still greater contribution to the profession have continued their education at community colleges or university schools of nursing in order to broaden opportunities and therefore better fulfill their original desire to help and serve mankind.

The practical nurse of the future, in terms of what she or he does rather than the title that is carried will undoubtedly be a major unit in the reorganized health care system of our country. The leadership of the L. P. N. must have access and ability to communicate not only with the professional nurse but also with the other health care professionals. Rather than being concerned with professional and institutional interests, nursing must always be concerned with the welfare of patients and the public it serves.

Eilene V. Buzzee, R. N., M.Ed.
Director of Nursing
Western Massachusetts Hospital
Westfield, Massachusetts

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The Visiting Nurse Association of Springfield

Today's critics of medicine are preoccupied with our current "nonsystem" of medical care. New philosophies and plans will come with new people, but the role and its extent in which Visiting Nurses already play in the transition, should be examined.

Today, the "physician's assistant" is a popular suggestion for increasing medical care services, but the physician already has another and less heralded assistant:—the community health nurse who provides nursing care for the patient at home.

Through the continuing pressures on physicians to find newer ways and more time to treat the sick, social pressure in communities, concerned but without adequate resources, the visiting nurse has found herself already functioning as a physician's assistant. Some physicians have always recognized that the Visiting Nurse makes the transition of a patient from the hospital to home not only feasible, but smoother, more comfortable and earlier. The physician's concern and the patients insecurity are allayed when there is a nurse helping to manage orthopedic appliances, colostomies, catheter, medications, etc. in the home.

Physicians are sometimes criticized for not using ancillary services for support and assistance. Yet, the fact that there are so many of these services available through agencies in the community makes it difficult for the busy physician to keep abreast of all of them. Therefore the physician may be better off by coordinating his efforts with the V. N. A.

Patients not referred by a physician (those whose requests for services are made by individuals, family and friends) may be visited once for evaluation purposes, but the patient must then be under medical direction if nursing service is to continue.

A quick glance over history reminds us that not too long ago most medical care was practiced in the homes and doctors offices. Today, however, hospitals are being utilized and too little care is accessible outside the hospital. Medical and technological advance have placed greater demands on hospitals and have been factors in the skyrocketing of costs of hospital care. The primary focus of health care must move back from the hospital to the ambulatory setting—reserving the hospital for short-term, expensive care for acute and complicated conditions. (cont.)

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The Visiting Nurse Association of Springfield is a team of registered nurses, licensed practical nurses, registered physical therapists, home health aides, homemakers, speech therapist and occupational therapist all able and dedicated to collaborate with the physician to care for his patient at home.

Physicians may request the following services of the Visiting Nurse Association:

—for patients needing skilled professional services—to permit early hospital discharge and avoid necessity of hospitalization;

—for maintenance care of elderly and chronically ill patients—with periodic consultation from physicians. These patients need minimal care to monitor their conditions and assist with personal care so that they can be cared for with dignity and satisfaction in their own homes at a cost far less than institutional care;

—for multi-discipline rehabilitation services when in-patient service is not feasible and home may be the preferred place of treatment.

The fee-for-service policy is in effect for each home-visit. Sources for payment vary with each patient. The V. N. A. is a certified Home Health Agency for the Medicare and Medicaid programs. Many private insurance policies cover visiting nurses services as well as other third party groups such as American Cancer Society, Division of the Blind, Veterans Service and Welfare.

Alexine Janiszewski Executive Director

Visiting Nurse Association

ARTICLE:

GOD REST YE MERRY AND WELCOME YE NEW YEAR.

The Holiday Season with its tradition of generosity and friendliness gives the physician an opportunity to express the motivations which have long characterized our profession. As the world turns from daily routines to a joyous recognition of good will to his fellow man, we can pause in the care of illness and injury to reaffirm our concern for our patients.

There are many forces at work today to separate the physician from his patient. Both the physician and the patient are partly responsible, but the major barrier is being erected by the "third parties". Economic harrassment and governmental regulation force the physician even farther from his primary aim of patient care. The public press and the public official assail our efforts and impugn our motives. This is a time to announce loudly the ideals of service and concern which make medicine a profession. If we are to live by these ideals throughout the year, we must convince the public of our intentions or we will lose our professional stature. Setting an example of professional competence is not enough. Our patients can no longer see this through the screen of third party obstruction.

(cont.)

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One area where physicians' motives can gain visibility is in concern for the religious needs of their patients. Regardless of your own religious persuasion, you can mobilize the faith of a patient to aid his recovery. Any illness brings elements of concern and uncertainty which are unique to each patient. Some of these can be controlled by the patient's faith in his physician. More serious illness and more complex fears require a greater measure of faith. The patient may already possess these resources or may need help from his physician or from others. When needed, an informed clergyman can be of significant asisistance, if you will enlist his aid. Preliminary contact between the professions will clarify the role of each, as with any consultation. This demonstration of concern for the patient's total welfare will pay significant dividends for both the patient and the physician.

We must pause in our committee work and our form filling to tell others of our devotion to the patient—the whole patient—mind, body, and spirit. Such expression is appropriate to the season, such ideals are appropriate throughout the whole year.

GARRY HOUGH, III, M.D.
MMS Committee on
Medicine and Religion

* * *

In Memoriam

ARTHUR E. GRAMSE, M.D.
1915 — 1973

Doctor Arthur E. Gramse of 234 Ellington Road, Longmeadow expired on the sixth of December 1973 in the Wesson Memorial Hospital. He was a surgeon who associated with the Mercy Hospital, the Holyoke Soldier's Home, the Shriner's Hospital and the Wesson Memorial.

Dr. Gramse was born in Holyoke and graduated from Williston Academy, received his AB from Yale in 1937 and his M.D. from the University of Maryland in 1942. Internship was in St. John's Hospital in Brooklyn, N.Y. His surgical residency was divided between St. John's and Children's surgery at Bellvue Hospital in New York.

He was licensed to practice in Massachusetts July 1942 and has been a member of the HDMS since 1949. He was a Fellow in the American and International Colleges of Surgery. In 1952 he earned a Master of Science in Surgery from the Univ. of Minnesota.

Throughout his illness he continued to show the spirit and determination to get back to his patients, as he did. Barnstable harbor also knew this fine surgeon and man.

#

Ernest A. Byron, Jr.

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It was but yesterday—my violin I held
An instrument born of strings and wood
Over two centuries ago its maker framed
But much before—a towering tree it stood.

Chiseled and carved, tenderly touched, passes day into night
Did he stop and dream—the years in flight
Who would possess this work of art
And give it beauty and life impart.

The violin alone lies lifeless and still
For without a bow—its bridges to pass—
'Tis but a sound box—forever mute until
Its strings are set in motion and alas!

It can now sing and speak—this is true
But its hollow frame—is void of joy or tears—for it has no soul
It is but the player who gives it life anew
His passion and anguish from his heart foretold.

Is this not true of our trodden passage through earth
We are alive, but only with a soul and in love
So long as someone imparts beauty and mirth
Into our hollow frame, to lighten our forest and set it aglow.

S. A. Z.

* * *

IN COMMON

In writing plays and getting laughs,
In taking decent photographs,
In racing Secretariat,
Or publishing the Hippocrat,
Or guiding kids through adolescence—
Time is always of the essence.

H. N. S.

* * *

BILL

Bill is eighteen. He has
A shy and friendly smile,
White teeth, and rumpled hair,
A pensive look,
An ugly scar beneath his undershirt,
And cancer.
Bill is eighteen, but he
Will never be nineteen.
His lesion lies beyond
The reach of surgeon's knife,
Conventional x-ray
Or Cobalt 60.
And so he's here,
And he and I pretend
He has some vague infection
For which he takes
Some strange and potent drugs—
Potent and yet so feeble—
With rolling names such as
Chlorambucil,
Actinomycin D, or
Methotrexate.
Some day some twentieth century alchemist,
Aided, perhaps, by serendipity,
May yet produce an oncolytic pill
To solve the problem that we hesitate
To talk about: he from courage,
I, perhaps, from cowardice.
But time is running out on Bill.
He cannot wait for alchemists,
He'll never be nineteen.

H. N. S.

* * *

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A MIDNIGHT RESOLVE – THE NEW YEAR 1974

The clock marked a minute, an hour, a day and a year.
The world and universe, in order, continued to turn.
A glass of sparkling, lifted to past tradition,
A brief review of resolutions forgotten or not fulfilled,
And with hope high and new resolutions made; let us all
Take a veiled glimpse ahead into uncertainty.

Sacrifice is no stranger to the physician and his wife,
Their goal will be to learn to again live within true needs.
When weighed against the necessities of others less fortunate
Displays of affluence and luxury will be in bad taste. Instead,
Sharing energy and things, planning for more than one family
To enjoy the pleasures of garden, hearth and home will only do.

Because of past experience and the possession of health and hope
And a belief in the ultimate order behind all things in life,
Therefore be it resolved —

"To live and love in a simplier way,
and to enjoy life from day to day."

W.E.S.

CORRESPONDENCE & LETTERS TO THE EDITORS

Allen S. Johnson, M. D.
36 Farmington Avenue
Longmeadow 6, Mass.
Dec. 17, 1973

Dear Walt:

I have read the December "Hippocrat" with great interest. Having served on the M. M. S. Committee on Ethics and Discipline for a dozen years and as an occasional lecturer to the medical students of both Tufts and B. U. on matters of Ethics I have developed a more than ordinary interest in the subject to which the current issue of the Hippocrat is devoted.

May I offer you the enclosed rebuttal. Perhaps "Set" would like to read it on its way to your waste basket.

Best Christmas and New Year's wishes.

Allen

ED: See page 34.

Senator Bennett
30 Nov. 73

ARTICLE: A Plea for Dignity in Dying

It is an interesting commentary on the compassion of civilized man that he has shown himself increasingly reluctant in recent years to accord his fellows that which he grants dumb animals as a matter of course; the right to die in peace. The stricken animal seeks, and usually finds, solitude wherein he may breathe his last,—free of the scientific legerdemain of young doctors dedicated to prolonging life but sometimes, alas, to prolonging dying. Such tranquility is too seldom granted the dying human if a hospital be the scene of his final victory over "the slings and arrows of outrageous fortune". The joyous act of human procreation may atone for its lack of dignity but at the opposite end of life's span there can be little justification for a denial of the dignity and tranquility with which we should be allowed to "shufflle off this mortal coil".

In my younger days I often pondered on the plight of the patient, dying in an oxygen tent, to whose burden of dyspnoea had been added claustrophobia and halitosis. I sometimes wondered if the satisfaction displayed by the family derived from their recognition that an oxygen tent symbolized the ultimate in terminal therapy or from the fact that the final struggles of the loved one were mercifully obscured by the scratched and clouded windows of the tent.

Today the moribund patient is subjected to equally well-intentioned but more ingenious harrassment. Like any other public utility, oxygen is piped in,—via nasal catheter. The day's menu is purveyed by vein. Lest the gastro-intestinal tract feel neglected, another tube explores the Stygian darkness of the upper gut. Bladder and rectum approach the embryonal unity of the cloaca by means of paired tubes dangling over the bedside. These are but the simple tethers by which the struggling spirit maintains a tenuous connection with a fading world.

For the desperately ill patient with a chance of recovery these ancillary devices deserve a place of honor not far below the miracles of modern medicine. For the doomed patient they represent a well-intentioned but ill-advised burden that is neither humane nor scientific. Where should the line be drawn? Does our pedagogic dedication demand that we demonstrate to our residents how long a pacemaker can maintain the circulation in a body from which the soul has fled? How long should mechanical respiration maintain breathing in a body whose brain has ceased to function? To answer "While there is a chance of recovery" is a deceptive over-simplification of the issue. Recovery for some means restoration to a meaningful existence. To others it means only the obligation to die a second time. Extremism is a philosophy not alone of politics. The physician dedicated to prolonging all lives at any cost is reluctant to assume the moral burden of selectivity. The decerebrate product of his therapeutic efforts weighs less on his conscience than does the aphasic hemiplegic who is allowed to expire peacefully with his stomata intact. The patient dying of unequivocally proven malignancy is entitled to tender, loving care and judicious sedation rather than intravenous feedings and an occasional transfusion to comfort his relatives. Throughout the ages the fear of death has been recognized as far more terrible than death itself, probably because of the misty impairment of perception with which nature enshrouds this final event. Why, then, must we tear away this merciful envelopment with modern therapies that can no longer turn back the hands of the clock? The prospect of dying may be a fearsome burden for the young but may be welcomed by the aged who "have finished their course". Each is entitled to every comfort which science and humanity can devise. The act of dying, whether observed in a bed or on the battlefield, is a far less frenetic affair than journalism suggests. Why, then, do we feel obliged to make it so burdensome and bereft of dignity? Should not the Golden Rule which is the keystone of medical ethics be applied in this most critical of human experiences?

No practitioner of experience need be reminded of the fallibility of medical judgment but the question of euthanasia is not at issue. Nor should any necessary modality of treatment be withheld from the patient who has the remotest chance of being restored to a meaningful existence. But as our population ages we are brought to the bedside of an increasing number of dying patients whose doom can no longer be a matter of debate. To them we owe one final debt; the right to die in peace and with dignity, free of the harrassment of futile therapy.

Allen S. Johnson, M. D.

Hampden Capsules and News Items:

The Editorial Staff of the *Hampden Hippocrat* announces with pleasure that Mrs. James Fitzpatrick has won the quarterly "Dinner for Two" award. Her Christmas poem was the best article submitted by a physician's wife during the last quarter of 1973. The contest will continue each quarter, so ladies take pen in hand and submit an article! It may be on any subject, but preferably about your husband or his profession, his hobbies or his philosophies on life.

The next meeting of the Springfield Academy of Medicine will be on Tuesday 12 February, 1974. Dr. Eldred D. Mundth will lecture on the subject "Current Status Of Coronary Surgery." The Academy wishes to remind its members that their wives are always welcome at its pre-program dinner and at the lecture. Call Mrs. Lund at 734-5445 for further details.

The Public Television Channel 57 will be beaming to western Massachusetts a series of medically oriented programs entitled KILLERS CLINIC. Air time will be 9:30 PM although the channel will start at 8:00 PM, with other subject material.

January 14, 1974
Pulmonary Disease—
The Hidden Enemy
February 11, 1974
Trauma
March 11, 1974
Cancer

Members of the Hampden District Medical Society have been active in assisting the programs' producer/director. You are encouraged to watch and it is suggested that you post a notice in your waiting room to alert your patients.

Dr. Burritt L. Haag has been elected to the board of directors of the New England Diabetes Association.

Dr. Zacarian delivered two scientific papers at the 2nd International Congress of Dermatology of Venezuela.

Drs. Ayres and Hayes attended the Clinical Meeting of the AMA in Anaheim. Dr. Hayes is a member of the House of Delegates and Dr. Ayres is President-Elect of MMS. Mrs. Purdy also attended the meeting.

Dr. Walter S. Mozden is president of the Mass. chapter of the American College of Surgeons.

For those interested persons, Senator Bennett's prepared text is on file in the HDMS office. Its length precludes full publishing in the *Hippocrat;* selected excerpts do not reveal the full message. It is suggested that those members who have difficulties in interpretation of the law of the land (PSRO) contact Dr. James Allen or Dr. John Ayres. Senator Bennett admirably explained and defined his amendment and most of those in attendance are convinced of the need for the statute and are willing to aid in its implementation.

One Man's Opinion . . .

MORE ON BYLAWS

"If a dozen people were designated individually to formulate a set of bylaws, the result would be 12 entirely different sets of bylaws."

—Anon.

A new revision of the bylaws of the Massachusetts Medical Society is to be acted upon at its Annual Meeting of May, 1974.

Now is the time to study the proposed changes, to ponder their significance and to let our leadership know how we feel about them. A copy of the Proposed Revision of the Bylaws is easily obtainable from the MMS headquarters, 22 The Fenway, Boston and a condensed version of it appeared in the Hampden Hippocrat of May, 1973.

A good beginning was made by Dr. John Ayres with his pertinent comments in the issue of May, 1973. Similarly pertinent were the observations by Dr. James Allan in the Hippocrat of September, 1973. One of the suggested changes is the creation of a Board of Trustees consisting of eight (8) members elected by the Council, plus the President, the President-elect and the Vice President of the MMS. Both John and Jim have expressed serious misgivings about the "Board" idea and not without reason. They argued that it lacked "representation from each district," and that it may lead "to a take-over by a small vested group for some self-serving purposes." Most disturbing is that, according to the proposed revision, it would take two thirds vote of the Council to override the Board's actions or recommendations. This means that the Board would be endowed with more authority and with greater power than the Council of which it is supposedly a mere "satellite."

It All Began in 1968.

The history of bylaws-revision dates back to 1968 when an Ad Hoc Committee to review the Bylaws of the MMS was created. The October Hippocrat of that year carried a suggestion which if implemented would have served to rejuvenate the Council to a considerable degree. This suggestion was submitted to our own Ted Miner, then a member of the Ad Hoc Committee. Specifically, the recommendation stipulated that councilors serve not more than five consecutive terms and that they not be eligible for re-election for at least two years. Its adoption, hopefully, would encourage the district societies to elect more youthful councilors than they do at the present time. Some of our incumbent councilors, it should be noted, have continued to serve uninterruptedly for fifteen years or even longer. This makes for inbreeding and prevents the infusion of younger blood into the ranks of the Council. Rejuvenation is probably what the framers of the proposed "Revision" had in mind when they opened the membership and Council doors to medical students, but this is hardly enough. What we need in the Council is not so much of undergraduates in their 20's as of MD's in their 30's and early 40's.

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A complaint often heard in hospital staff rooms is that organized medicine is too slow in initiating programs and too sluggish in implementing them. Instead of *acting* we are merely *reacting* and instead of *punching* we are only *counter-punching*. At this late date the MMS has yet to declare its position on such matters as abortion and on acupuncture. It is sincerely hoped that the creation of the post of Executive Vice President, as proposed by the "Revision" Committee, will serve to expedite matters in more ways than one. In this day of rapid change a modus operandi must be evolved to cope promptly with all problems that may emerge in the fields of public relations, medical legislation and socio-economics. The creation of a new post of a paid, full time Executive Vice President may well serve the purpose.

The proposed "Revision" contains a number of other excellent recommendations. If adopted these recommendations should ease the burdens and responsibilities of the president. They will eliminate some committees and consolidate others. Finally, they may even bring about a much needed improvement in our internal or intra-mural relations. An AMA movie shown recently at one of our District meetings stressed the importance of this type of relationship. We are living today in an age of polarization, polarization as to age, specialties and even geography. What is needed are such changes in our parliamentary structure as will result in greater unity in our midst. We need better and more meaningful communication between the leadership and the membership, as well as between Boston and the rest of the state. Some of the proposed changes reflect a sincere desire on the part of the Bylaws Committee to bring about a number of these improvements. Its members are entitled to our opinion, comments and suggestions. A letter to "Dear Hippocrat" is probably the easiest and simplest way for those of us in Hampden to speak out and to make our views known to the Committee to Revise the Bylaws of the Massachusetts Medical Society.

Max Millman

* * *

Guests at HDMS' November Meeting.

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